

# REPORT OF INDEMNITY PAYMENT (DWC-22)

## General Instructions:

- Completed by: Claim Administrator.
- Time Frame: As a Termination of Benefits under Non-Prejudicial Agreement: Within ten days of the termination of benefits. As a payment under Memorandum of Agreement (MOA): Initial report should be attached to MOA. Additional reports are due every six months on an ongoing claim **or** any time there is any change in the compensation rate (i.e. COLA or change in dependents).
- Distribution: Original to Department of Labor and Training. When used as a Termination of Benefits under Non-Prejudicial Agreement, copies must be sent to employee and his or her attorney within ten days of the termination of payments.
- Attachments: When submitting a *final* payment report under an MOA, a Suspension Agreement and Receipt (DWC-5) should be attached.

## Definitions:

- **PLEASE CHECK IF CORRECTION OF PRIOR REPORT:** Check if sending in an amended form.
  - **YOU *MUST* CHECK ONE OF THE FOLLOWING:**
    - *Termination of Benefits Under Non-Prejudicial Agreement:* Check **only** when ending benefits under a Non-Prejudicial Agreement.
    - *Payment under Memo of Agreement, Order or Decree:* Check when appropriate.
  - **YOU *MUST* CHECK ONE OF THE FOLLOWING:**
    - *Report type: Final or Interim:* Check *Interim* when weekly indemnity payments will continue. Check *Final* when weekly indemnity payments have ended. Termination of Benefits will always be a *Final*.
    - *If final, date of last weekly indemnity payment:* Enter the date of the last weekly indemnity check.
- 1. Employee Information:**
- *SSN:* Employee's Social Security Number.
  - *Name:* Employee's full name.
  - *Address (including city, state, zip):* Employee's current mailing address.
  - *Phone:* Employee's current home telephone number.
  - *Date of Birth:* Date the employee was born.
- 2. Claim Information:**
- *Employer:* Employer's actual name where the employee was employed at the time of the injury.
  - *Insurance Co.:* Name of the worker's compensation insurer OR 'Self-Insured' if the company has been certified as self-insured by DLT.
  - *Claim Administrator:* Name of the WC insurance carrier, third party administrator, or self-insured employer responsible for administering the claim.
  - *Injury Date:* Date that the accident happened.
  - *Incapacity Date:* First full day that the employee lost from work (include weekends and holidays).
  - *Date of Death:* Conditional, if employee died – Check box if death was NOT work-related.
- 3. Rate Information:**
- *AWW including Overtime:* Enter appropriate figure as listed on Agreement, Order or Decree.
  - *Spendable Base Wage:* Enter appropriate figure as listed on Agreement.
  - *Base Compensation Rate:* Enter appropriate figure as listed on Agreement.
  - *AWW (include bonus/no OT):* Enter appropriate figure as listed on Agreement.
  - *Total Cost of Living Adjustment(s):* If claimant is entitled, enter total cumulative amount calculated for [Cost of Living Adjustment](#).
  - *Weekly Dependency Rate:* **Total Incapacity Only.** \$15 per dependent or \$40 per dependent for death claim.
- 4. Weekly Compensation:**
- *Indicate Payment Type:*
    - *TI:* Total Incapacity
    - *PI:* Partial Incapacity
    - *DB:* Death Benefits
  - *Payment period Date from:* Date of Incapacity (first full day without wages). Do **not** adjust date for three-day waiting period.
  - *Payment period Date through:* Last date of the benefit period for which benefits were paid.
  - *Number of Weeks & Days:* Number of weeks and days that the payment represents. Three-day waiting period may be deducted here.
  - *Total Weekly Rate:* Total weekly compensation rate used.
  - *Variable Partial Total Spendable:* Only use when paying 'variable' or 'working' partial. Total amount of Spendable Earnings for the weeks of variable partial as listed in Section 5 of this form. See [Calculation of a Variable Partial](#) for more information.
  - *Compensation Paid:* Total compensation paid.
  - *Settlement/Deny & Dismiss:* Enter amount of settlement or D&D, WC Court Decree number, and date of Decree.
- 5. Weekly Compensation for Variable Partial Payments:**
- *Week Ending:* Week ending date for the Gross Earnings listed.
  - *Gross Earnings:* Total weekly gross earnings of claimant.
  - *Spendable Base Wage:* Enter appropriate figure from [Gross Wage to Spendable Earnings Table](#). Note: If paying Suitable Alternative Employment (SAE) write 'SAE' in the Spendable Earnings column and complete other columns as noted.
  - *Amount Paid:* Amount paid by the claim administrator for that week.
  - *Signature/Date:* Signature of the person who filled out the form and the date that the form was prepared.
  - *Print Name/RI Adjuster License Number/Phone & Extension:* Clearly enter the name of the person who filled out the form, their RI Adjuster License Number as issued by the RI Department of Business Regulation, and the complete phone number of the preparer. Note: DO NOT ENTER SSN – Request another number from DBR.